London, and the American Academy of Neurology, have weighed in with proposals and remedies.[5 6] Everyone agrees that the teaching of basic neuroscience and clinical neurology must be more effectively integrated, that sufficient time for neurology must be allotted in an already overburdened curriculum, and that every practising doctor must be prepared to handle common neurological disorders and emergencies. Neurologists are also discovering that there are reciprocal benefits for teaching and patient care from collaboration with other groups. For example, advances in neuroscience research have now made it untenable to draw a sharp demarcation line between the twin educational domains of neurology and psychiatry, and the Department of Mental Health and Substance Dependence of the World Health Organization has inaugurated a collaboration to grapple with these and related issues. In the United States, neurological teachers have also joined forces with their counterparts in primary care to develop and implement a family practice curriculum in neurology, intended to enlarge the range of settings in which educational programmes are carried out (CD Rom available from the American Academy of Neurology, kjones@aan.com).

About 50 years ago, Morris B Bender rightly concluded that the bottom up pathway in neurological education—from basic science to clinical problems—was becoming dysfunctional and instituted a top down approach starting with clinical signs instead, by means of phenomenology seminars. In origin, as described by philosopher Edmund Husserl, phenomenology is the intuitive appreciation of phenomena as they are immediately perceived, without reference to scientific theory or prior learning.[7] Teaching phenomenology in neurology rivets the attention of learners to an arm that shakes, an incomprehensible word, or a person lost in the world. Explanations and interpretations "to save the phenomena" follow, but do not precede or coincide with, awareness. Clearly, phenomenology is an approach that starts with the patient's perspective (illness) and only later shifts to the doctor's perspective (disease). Such teaching shifts emphasis from the passive methods so widespread in medical education to more active, self directed, and independent study.[5]

The a priori method of phenomenology represents a radical departure from the prevailing educational paradigm of the 20th century. This general approach, with neurology as an example, is possibly applicable in other clinical fields. As there are fewer born teachers than born poets, however, success hinges upon the availability of adequate resources to promote and sustain a cadre of seminar leaders who are both content experts and teachers trained as educators.[5]

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Iatrogenic stigma of mental illness

Begins with behaviour and attitudes of medical professionals, especially psychiatrists

The stigma attached to mental illness, and to the people who have it, is a major obstacle to better care and to the improvement of the quality of their lives.[1] The World Psychiatric Association has recently initiated a global programme against stigma and discrimination because of schizophrenia.[2] Twenty countries are participating in the programme, and others have expressed their interest in joining.[3] The programme of the World Psychiatric Association is different from others in three ways. Firstly, it begins by an examination of experiences that patients and their families have had since the illness started. The analysis of accounts of their experiences in relation to society serves to select targets for interventions that will aim to reduce stigma and its consequences. Secondly, it involves different social sectors—for example, health ministries, social welfare services, labour ministries, non-governmental organisations, and the media. Thirdly, the programme is not a campaign but a long term engagement. Because of the strategy adopted for the programme, its focus differs from one place to another. For example, in Canada, one of the first targets of the programme was a change in procedures used in emergency departments that discriminate against people with mental illness. In Italy, the attitudes of shopkeepers were the target and in Germany, the reporting about mental illness in the media. Certain themes and sources of stigmatisation, often neglected, emerge as worthwhile targets in most places. Among them are the behaviour of medical professionals (psychiatrists in particular[4]) and the contribution of the people with the disease who, for a variety of reasons, lose their self confidence and self respect, which changes their relationships with others and their way of life.

A most obvious source of stigmatisation is the careless use of diagnostic labels. Diagnoses are useful tools in medicine because they summarise the information about a patient's illness and facilitate communication among members of the profession. They become less helpful in communication with other professions and can be harmful when used by non-professionals who are not familiar with the original definition of the term. Even doctors must communicate by diagnoses in a careful and restrained manner. The public and health professionals often have negative attitudes to people with mental illness and will behave accordingly once

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they are told that a person has an illness about which they have prejudices. Health systems that require that medical decisions be based on diagnoses without having resources that would ensure appropriate protection of diagnostic information about the patient are also to be blamed. Being conscious of the power of diagnosis and of the labelling process might contribute to a wiser use of diagnoses, but removing the diagnosis by itself would not eliminate stigma.

Iatrogenic stigmatisation unfortunately does not stop at labelling. Treatment of symptoms of mental illness may produce side effects (for example, extrapyramidal signs), which will mark the person as having a mental illness more than the original symptoms of illness did. Governments sometimes support the use of cheaper treatments even when the side effects are profoundly disturbing or painful. Medical practitioners accept such policies, although it is clearly their duty to fight such regulations and ensure that their patients receive the best treatment, which is often not the cheapest.

Psychiatrists and other mental health staff also stigmatise patients in other ways. Until recently psychiatrists in some European countries and elsewhere were requesting longer holidays and a higher salary than other doctors because they had to work with mentally ill patients who are dangerous, while arguing, at the same time, that mental illness is no different from other illnesses. Psychiatrists are among those who recommend separate legislation for people with mental illness to protect some people with mental illness, often unaware of the effect that such legislation might have on all other patients. They should certainly continue to do whatever is necessary to protect their patients; but it would help if they also advocated the notion that the rights and duties of people with mental illness should be decided by their behaviour and capacities in the same manner as for other people rather than by the diagnostic label alone.

Directors of institutions and hospitals in which people with mental illness are treated or find shelter rarely insist that their clients should be given an opportunity to participate in elections or other voting. The installation of ballot boxes in mental hospitals is still a rarity even in countries where there is much awareness of the need to protect human rights and social rights of those with mental illness. How should we convince others that most people with mental illness retain many of their capacities and that their rights are often not respected if we do not show the way by our own behaviour? General healthcare staff only rarely joins psychiatrists in requesting equal provisions for the care of people with mental illness. Alison Gray in a recent review article urges medical professionals to consider their own attitudes and become aware of them, to involve service users in the development of services, and to stand up against discrimination because of mental health problems wherever it might occur. Hopefully health professionals will be influenced by her views.[5]

The above examples are listed to remind us that we psychiatrists and other medical professionals are not sufficiently engaged in fighting stigma and discrimination related to mental illness; what is worse, we may be contributing to it in various ways. It would be useful if all of us were to examine our own behaviour and actions and change them where necessary to reduce stigma. Stigma remains the main obstacle to a better life for the many hundreds of millions of people suffering from mental disorders and their consequences. We must make our contribution to eliminate stigma and fight it in every way possible.

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Diagnosing brain death without a neurologist

Simple criteria and training are needed for the non-neurologist in many countries

"death hath ten thousand several doors
For men to take their exits."
John Webster, *The Duchess of Malfi*, 1612[1]

When nature takes its course the heart stops beating or the lungs stop breathing as a sequence of events unfolds, ending with death eventually overcoming the last cells of our bodies. The vast majority of the world's people leave life through doors marked "death from natural causes." During the last decades some new doors for death have been opened by medical progress and by the law. Palliative medicine strives to ease the final step over the threshold, extending the physician's traditional role by using modern medicine.[2] In some places, two other doors have recently been unlocked: medically assisted suicide has been legalised in the Netherlands, the American state of Oregon, and Belgium, and euthanasia has been legalised in the Netherlands and Belgium. Knocking at the doors of (medically) assisted suicide has not met with success in the US Supreme Court[3] nor in the European Court of Human Rights.[4]

Modern medicine has also given us tools as never before to oppose death. If this battle is lost, defeat reveals yet another aspect of death. Let us consider that brain functions fail to the point where the clinical criteria of brain death are fulfilled[5 6]; without artificial support, respiratory failure ensues, followed by natural death. When artificial support interferes with this process the result can be an unintended biological artefact: a body with an irreversibly damaged brain is diagnosed as brain dead.[5 6]

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